MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Texas Imaging & Diagnostic Center 3840 W. NW. Highway, Suite 400 Dallas, Texas 75220	MDR Tracking No.: M4-03-4276-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address The Travelers Companies Box 05	Date of Injury: Employer's Name: Insurance Carrier's No.: 039CBAVV5764

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
05/08/03	**05/08/03**	**72148**	**$101.00**	**$101.00**

PART III: REQUESTOR'S POSITION SUMMARY

"In our dispute we are including a letter from our nurse listing the necessary requirements and how we meet them, copies of our supply sheets describing charges and EOB's from various insurance companies that pay this code in full and in accordance with TWCC fee guidelines."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not submit a position statement. EOB states, "This bill has been processed correctly per the State Fee Schedule."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The provider submitted documentation that supports the number of slices performed for this MRI, per MFG Radiology (II)(C)(3). The requestor billed for 90 slices and used the WP 22 modifier, which is used for more than 25 slices. The MAR for CPT code 72148 E is $924.00. Carrier reimbursed the requestor $823.00 leaving $101.00 in dispute. No other denials were noted in the claim file.

Therefore, based on the information provided additional reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

				Total Left Column:			$0.00
				Total Amount Due:			$101.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled reimbursement in the amount of **$101.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

Ordered by:

	Michael Bucklin	01/10/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____